# MEDICAL TRANSPORTATION STATEMENT - CHRONIC ONGOING TREATMENT

**Document Number**

**Michigan Department of Community Health**

- Use only **ONE** medical provider and **ONE** transporter per form.
- See **Page 2** for Instructions, Copy Distribution, PA 431 and Non-Discrimination Information.

## SECTION I - FIA Specialist Completes:

| FIA Specialist Name | | Phone No. ( ) | | Authorized Rate Standard ☐ Special ☐ | | | Patient/ Beneficiary Name | Beneficiary ID No. |
|---|---|---|---|---|---|---|---|---|
| FIA Case Number | Prog. Code | CO # | DIST # | SEC | UNIT | FIA SPEC | Address (No. & Street, City, State, ZIP Code) | |
| | | | | | | | | |

## SECTION II - Medical Provider Completes:

| Medical Provider's Name (MD, DO, DDS) | Soc. Sec. No. or ID No. | Address (No., Street, Bldg., Suite, etc.) | Provider's Phone No. ( ) |
|---|---|---|---|
| Chronic, ongoing illness? (This usually means monthly ongoing care, but may include less than monthly care.) ☐ YES ☐ NO | Is overnight stay required? ☐ YES ☐ NO | City, State, ZIP Code | |
| Does someone need to accompany the patient to the medical appointment? ☐ YES → ☐ NO | If YES, Who & Why | Does patient need special transportation? ☐ YES → ☐ NO | Type (Van w/ wheelchair lift, etc.) |

## SECTION III - Transportation Provider Completes:

| Transportation Provider's Name (Last, First) | Soc. Sec. No. or ID No. | Type of Transportation | Other Expenses (Parking Receipts, etc.) |
|---|---|---|---|
| Transportation Provider's Complete Address (No. & Street, City, State, ZIP Code) | | | Phone No. ( ) |

## SECTION IV - Transportation Record:

| APPOINTMENT DATE | ROUND TRIP MILEAGE | ATTENDANT FEE | APPOINTMENT DATE | ROUND TRIP MILEAGE | ATTENDANT FEE |
|---|---|---|---|---|---|
| 1. | | | 8. | | |
| 2. | | | 9. | | |
| 3. | | | 10. | | |
| 4. | | | 11. | | |
| 5. | | | 12. | | |
| 6. | | | 13. | | |
| 7. | | | **TOTALS** | | **$** |

| | | |
|---|---|---|
| **MEDICAL PROVIDER:** I certify that I am a Medicaid enrolled provider and that I provided a medical service on the date(s) listed above. | Medical Provider Signature | Date |
| **TRANSPORTER:** I certify that I provided Medical Transportation Service on the date(s) listed above. | Transporter's Signature | Date |
| **BENEFICIARY:** I certify that I received Medical Transportation Service on the date(s) listed above. | Beneficiary's Signature | Date |

## SECTION V - Local FIA Specialist & Manager Complete:

| | | | | | |
|---|---|---|---|---|---|
| A) Total Number of Miles X $0.12 | $ | D) Greater of Line A or $1.80 | $ | FIA Specialist's Signature | Date |
| B) Special Rate (FIA-54A Received) | $ | E) Other Expenses | $ | FIA Manager's Signature | Date |
| C) Total of Lines A + B | $ | F) Total Authorized: Special Rate = C + E; All Other = D + E | $ | | |

## SECTION VI - Local FIA Accounting Use Only:

| Audited and Approved by: | | Date | Doc. Type | Intf. Type | PDT | Bank ID No. | DMI |
|---|---|---|---|---|---|---|---|
| Appr. Yr. | Index | PCA | Agency Object Code | | | Amount $ | |
| NIGP Code | MAIN/LOAAS Doc. No. | Check No. & Date | LOAAS Account No. | | | | |



MSA-4674A (01/2004) (w) Previous editions may be used.

# Instructions for MSA-4674A

## (Medical Transportation Statement - Chronic Ongoing Treatment)

## GENERAL INSTRUCTIONS:

- **Use one form per month for each medical provider or transporter.**
- Use this form to show multiple trips made in a calendar month to the same medical provider (e.g., kidney dialysis treatment).
- This form must be returned to the local Michigan Family Independence Agency within **90 days** of a given medical appointment date to receive payment for medical transportation.

## COMPLETION INSTRUCTIONS:

**SECTION I:**

- The FIA Specialist completes this section.

**SECTION II:**

- The medical provider completes this section. (**Only one medical provider per form**.)

**SECTION III:**

- The transportation provider completes this section.
- Use only **ONE** transporter per form.
- Leave this section BLANK if the Beneficiary drives themselves OR if the Beneficiary wishes to receive the transportation payment directly.

**SECTION IV - Transportation Record:**

**Medical Provider:**

- Enter the **dates** of appointments for the whole calendar month.
- **Sign below** the individual date lines **after** all of the dates for the month have been entered to verify that each individual medical appointment did occur.

**Transporter:**

- The transporter enters the following for each appointment / visit: **round trip mileage** and the **attendant fee** if medically authorized.
- **Sign below** the individual date lines **after** all of the dates for the month have been entered to verify that transportation services were provided for EACH individual medical appointment.
- If SECTION III was **completed**, then only **that transporter** may sign in this section.

**Patient / Beneficiary:**

- **Sign below** the individual date lines **after** all of the dates for the month have been entered. This verifies that the Beneficiary kept each medical appointment and transportation services were provided.

**SECTION V:**

- The FIA Specialist calculates the transportation payment and signs their name.
- The FIA Manager reviews the entire form and signs their name approving the payment.

**SECTION VI:**

- The local FIA Accounting Unit completes this section.

## COPY DISTRIBUTION:

Original:
- Mail or give this copy to the **Beneficiary** for completion by the Beneficiary, medical provider and the transporter.
- **Return to FIA Specialist** for completion. Forward to the local FIA Accounting Unit for payment processing.

Copy 1:
- Local FIA Case File copy

Copy 2:
- Give this copy to the Beneficiary and/or Transporter.

| | | |
|---|---|---|
| AUTHORITY: | Title XIX of the Social Security Act | The Department of Community Health is an equal opportunity employer, services and programs provider. |
| COMPLETION: | Is Voluntary but required if payment from applicable programs is sought. | |



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